MEDICAL HISTORY

Last Name: ______________ First Name: ______________ Date of Birth: __________

Name of Medical Doctor: ______________ Date of last visit to medical doctor: __________

List all medications that you are now taking:

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Darvon	☐	☐	Tetracycline	☐	☐	Other Antibiotics
☐	☐	Codeine	☐	☐	Percodan	☐	☐	Local Anesthetic (Novocain or Xylocaine)
☐	☐	Demerol	☐	☐	Valium			
☐	☐	Nitrous Oxide	☐	☐	Scopolamine	☐	☐	Sleeping Pills (Nembutal/ Seconal)
☐	☐	Sulfa						
☐	☐	Other: ______________						

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N	
☐	☐	Heart Failure	☐	☐	Emphysema	☐	☐	HIV Positive
☐	☐	Heart Disease or Attack	☐	☐	Venereal Disease (Syphilis, Gonorrhea)	☐	☐	Hepatitis A (Infectious)
☐	☐	Angina Pectoris	☐	☐	Tuberculosis (TB)	☐	☐	Hepatitis B (Serum)
☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐	Herpes
☐	☐	High Cholesterol	☐	☐	Hay Fever	☐	☐	Liver Disease
☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐	Yellow Jaundice
☐	☐	Rheumatic Fever	☐	☐	Allergies or Hives	☐	☐	Blood Transfusion
☐	☐	Congenital Heart Lesions	☐	☐	Diabetes	☐	☐	Drug Addiction
☐	☐	Scarlet Fever	☐	☐	Thyroid Disease	☐	☐	Hemophilia
☐	☐	Artificial Heart Valve	☐	☐	X-ray or Cobalt Treatment	☐	☐	Cough
☐	☐	Heart Pacemaker	☐	☐	Cancer	☐	☐	Cold Sores
☐	☐	Heart Surgery	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐	Fever Blisters
☐	☐	Artificial Joints (Hip, Knee)	☐	☐	Arthritis	☐	☐	Epilepsy or Seizures
☐	☐	Anemia	☐	☐	Rheumatism	☐	☐	Fainting or Dizzy Spells
☐	☐	Stroke	☐	☐	Cortisone Medicine	☐	☐	Nervousness
☐	☐	Kidney Trouble	☐	☐	Glaucoma	☐	☐	Psychiatric Treatment
☐	☐	Ulcers	☐	☐	Pain in Jaw Joints (TMJ)	☐	☐	Sickle Cell Disease
☐	☐	Cosmetic Surgery	☐	☐	A.I.D.S.	☐	☐	Bruise Easily
☐	☐	Other: ______________						

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Patient/Guardian Signature Date: 01/26/2023 Doctor Signature Date: 01/26/2023